INTRODUCTION

This report is submitted pursuant to s. 46.27(11g) and s. 46.277(5m), of the Wisconsin Statutes, which requires summary reporting on state funds appropriated in the biennial budget process for the Community Options Program. The Community Options Program (also known as COP-Regular or Classic COP) serves all client groups in need of long-term care and is entirely state-funded.

The statutes also permit Community Options Program funds to be used with the flexibility to expand Medicaid waiver programs. The federal government grants waivers of Medicaid rules to permit states to provide long-term care at home to a population that qualifies for Medicaid coverage of nursing home care. State funds are matched by federal Medicaid dollars at a ratio of about 40:60. The Community Options Program-Waiver (COP-W) is limited to persons who are elderly and/or persons with a physical disability. The Community Options Program-Waiver also includes the Community Integration Program II (CIP II).

Other Medicaid waiver programs are targeted to specific populations in need of long-term care services. Community Integration Program 1A (CIP 1A), Community Integration Program 1B (CIP 1B), Community Supportive Living Arrangements (CSLA) and Brain Injury Waiver (BIW) all serve the community needs for long-term care participants with developmental disabilities. The Community Options Program state funding is often used as a match for federal funds through these waivers.

This report describes the persons served, program expenditures and services delivered through the Community Options Program, Community Options Program-Waiver and Community Integration Program II in calendar year 2000. Medicaid waiver funding combined with Medicaid card funded services (acute care) and COP, provide a comprehensive health care package to recipients. It is critical that these programs be closely coordinated in order to ensure that the most comprehensive and individualized care is provided. With this kind of coordination, Wisconsin residents are provided with a safe, consumer-controlled alternative to life in an institution. As this report demonstrates, these programs also help to contain the costs of providing long-term care to a fragile population.

STRUCTURE

The Community Options Program and Community Options Program-Waiver funds are administered by the Department of Health and Family Services, and the programs are managed by county agencies. These funds are allocated to counties based on the Community Aids formula (base allocation) or for special needs, such as nursing home relocations.

The success of the Community Options Program is measured both by how well the program is able to help contain the use and cost of Medicaid-funded nursing home care, and by producing positive outcomes for the program participants. COP and COP-W together provide complementary funding to enable the arrangement of comprehensive services for people in their own homes based on the values of consumer direction and preference. The coordination of county resources is outlined in the local Community Options Program Plan, a description of the county policies and practices, which assures the prudent, cost-effective operation of the Community Options Program. Each county COP plan is updated annually with approval by the local Long-Term Support Planning Committee.

State level program management monitors local compliance with statutory program requirements, including:

- significant proportions;
- allowable residential settings;
- county COP plan approval; and
- the mandated use of the federally-funded home and community-based Medicaid waivers prior to using the state-funded COP.

PARTICIPANTS SERVED BY PROGRAMS

The following table provides information about the numbers of participants in various waiver programs. The Community Options Program, in combination with Medicaid waiver funds, is used to support individuals in the community. The program category column in Table 1 lists each funding source by type of Medicaid waiver, and when each waiver is combined with COP funding. (See Appendix B for definitions of community long-term care programs.) The categories of participants are (vertical) elderly, persons with physical disabilities (PD), persons with developmental disabilities (DD), persons with severe mental illness (SMI), and persons with alcohol and/or drug abuse (AODA).

TABLE 1
Participants Served by Programs

Program Category	Elderly	PD	DD	SMI	AODA	Other	Participants Served with Medicaid Waiver Funds Only	Waiver Participants with Additional COP	Total Participants Served Unduplicated
COP-W									**10,750**
Waiver Only	6,501	1,491					7,992		
Waiver/COP	2,307	451						2,758	
CIP II									**2,796**
Waiver Only	950	1,018					1,968		
Waiver/COP	479	349						828	
Sub Total COP-W/CIP II	**10,237**	**3,309**					**9,960**	**3,586**	**13,546**
CIP 1A									**1,157**
Waiver Only	34		1,023				1,057		
Waiver/COP	10		90					100	
CIP 1B Regular									**2,424**
Waiver Only	159		2,101				2,260		
Waiver/COP	36		128					164	
CIP 1B/CSLA COP Match									**2,305**
Waiver/COP for match only	122		1,817				1,939		
COP match waiver w/other COP	32		334					366	
CIP 1B/CSLA Other Match									**3,482**
Waiver/other for match	135		3,241				3,376		
Waiver/COP	12		94					106	
Brain Injury Waiver									**216**
Waiver Only	1		192				193		
Waiver/COP	0		23					23	
Sub Total Developmental Disabilities Waivers	**541**		**9,043**				**8,825**	**759**	**9,584**
COP Only Participants	**1,428**	**206**	**155**	**1,002**	**19**	**41**			**2,851**
Totals by Target Population	**11,863**	**3,452**	**9,195**	**1,159**	**31**	**281**	**18,785**	**4,345**	**TOTAL 25,981**
% Served by Target Population	**45.7%**	**13.3%**	**35.4%**	**4.5%**	**0.12%**	**1.08%**	**72.3%**	**16.7%**	

- Total unduplicated participants served in 2000 - 25,981.
- Total participants who were served by a Medicaid waiver only (no COP funds) - 18,785.
- Total Medicaid waiver participants who also received COP funding in CY 2000 - 4,345.
- Total participants who received only COP funding (not Medicaid eligible) - 2,851.
- All participants who received either pure COP or COP supplementing funds - 7,196.
- Total participants served with COP and COP-W funds - 17,127.

PARTICIPANTS SERVED BY TARGET GROUP

The Community Options Program and the entire home and community-based waivers served a total of 25,981 persons. The table below illustrates participants served with COP and Medicaid waiver funding by target group in 2000.

TABLE 2
Participants Served by Target Group

Target Group	COP Only	COP-W	Subtotal COP Only, COP-W	CIP II	Subtotal COP Only, COP-W, CIP II	CIP 1, CLSA, BIW	GRAND TOTAL
Elderly	1,428 50.1%	8,808 81.9%	**10,236** **75.3%**	1,429 51.1%	**11,665** **71.1%**	541 5.6%	**11,863** **45.7%**
PD	206 7.2%	1,942 18.1%	**2,148** **15.8%**	1,367 48.9%	**3,515** **21.4%**	0 0%	**3,452** **13.3%**
DD	155 5.4%	0 0%	**155** **1.1%**	0 0%	**155** **0.9%**	9,043 94.4%	**9,195** **35.4%**
SMI	1,002 35.1%	0 0%	**1,002** **7.4%**	0 0%	**1,002** **6.1%**	0 0%	**1,159** **4.5%**
AODA	19 0.7%	0 0%	**19** **0.1%**	0 0%	**19** **0.1%**	0 0%	**31** **0.12%**
Other	41 1.4%	0 0%	**41** **0.3%**	0 0%	**41** **0.3%**	0 0%	**281** **1.08%**
Total	**2,851** **11.0%**	**10,750** **41.4%**	**13,601** **52.3%**	**2,796** **10.8%**	**16,397** **63.1%**	**9,584** **36.9%**	**25,981** **100.0%**

- 11,863 or 46% were elderly;
- 3,452 or 13% were persons with physical disabilities (PD);
- 9,195 or 35% were persons with developmental disabilities (DD);
- 1,159 or 5% were persons with severe mental illness (SMI); and
- 312 or 1% were persons with alcohol and/or drug abuse (AODA) or other conditions.

FIGURE 1
Participants Served by Target Group
COP and All Waivers

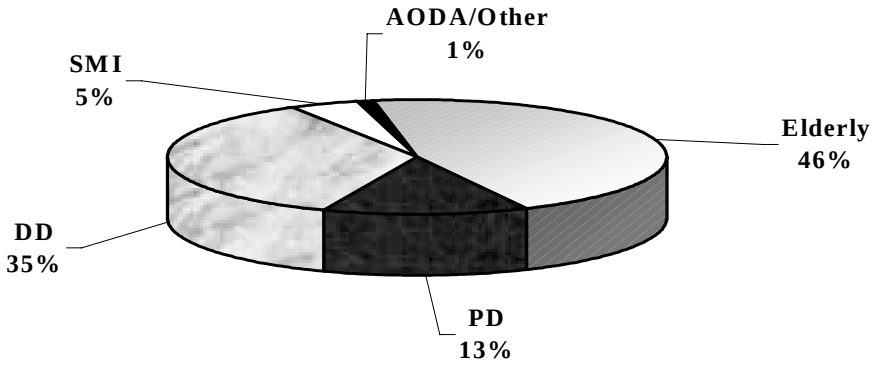


FIGURE 2
Point-in-Time Percentage of Persons Receiving COP, COP-W and CIP II Services
Participants by Target Group on December 31, 2000

Figure 2 depicts the percentage of persons from each COP target group who received COP-Regular, COP-W and CIP II services on December 31, 2000. Statewide, the proportions of persons served exceed the targets for all target groups.

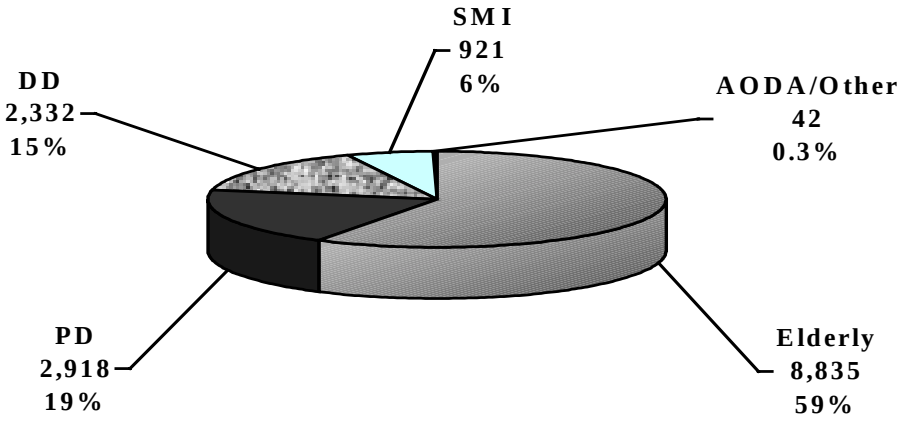
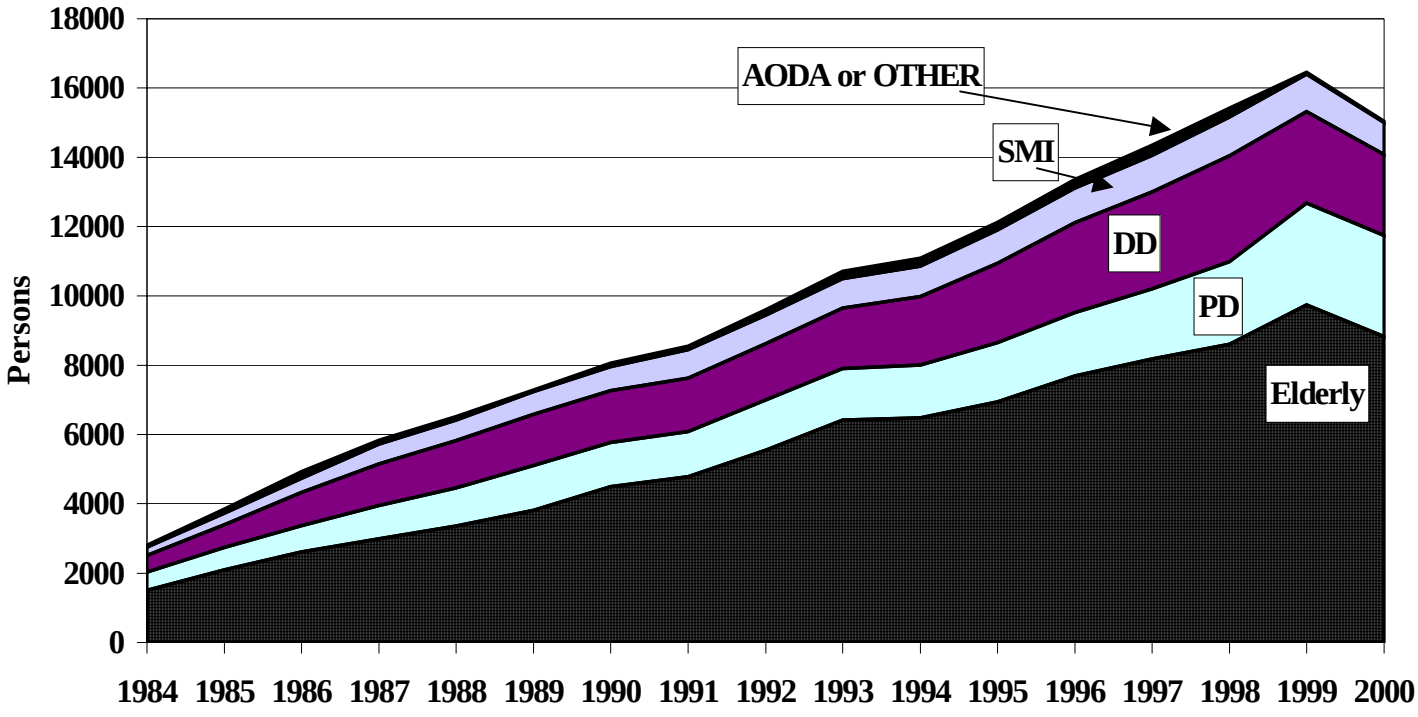


FIGURE 3
Point-in-Time Count of Persons Receiving COP, COP-W and CIP II Services
December 31, 1984 – December 31, 2000

Figure 3 illustrates that there was a decline* of participants for all target groups in 2000 compared to 1999. The target group's overall proportions remained about the same in 2000 compared to 1999.



* Decline – 1,444 persons switched to Family Care in 2000.

COP ASSESSMENTS, CARE PLANS AND PERSONS SERVED

The Community Options Program lead agencies provide eligible individuals with an assessment and care plan that identifies equipment, home modifications and services that might be available to assist them in their own homes and communities. During the assessment process, a social worker and other appropriate professionals assess each individual's unique characteristics, medical condition, living environment, lifestyle preferences and choices. The individual and the care manager develop a plan for a comprehensive package of services, which integrates and supports the informal and unpaid assistance available from family and friends. This care plan incorporates individual choices and preferences for the type and arrangement of services. Depending upon available income and assets, the individual may be responsible for paying some or all of the costs for services in their care plan.

In 2000:
- **9,933** **Assessments** were conducted.
- **5,566** **Care plans** were prepared.
- **3,852** **New persons** were served with COP-Regular and/or COP-W.
- **13,275** **Persons** continuing COP/COP-W services began services prior to 2000.
- **17,127** **Total persons** served with COP-Regular and/or COP-W funds in 2000.

Participation in the Community Options Program increased steadily from 1982 to 1999; however, the total number of people served in Calendar Year 2000 declined by 849 participants compared to 1999. Since the beginning of COP, on average, one-third to one-fourth of the total persons served each year have been new participants who were not served in the previous year. Resources for new participants are either from new state funding or funds that become available as other participants leave the program.

TABLE 3
COP Assessments, Care Plans and Persons Served*

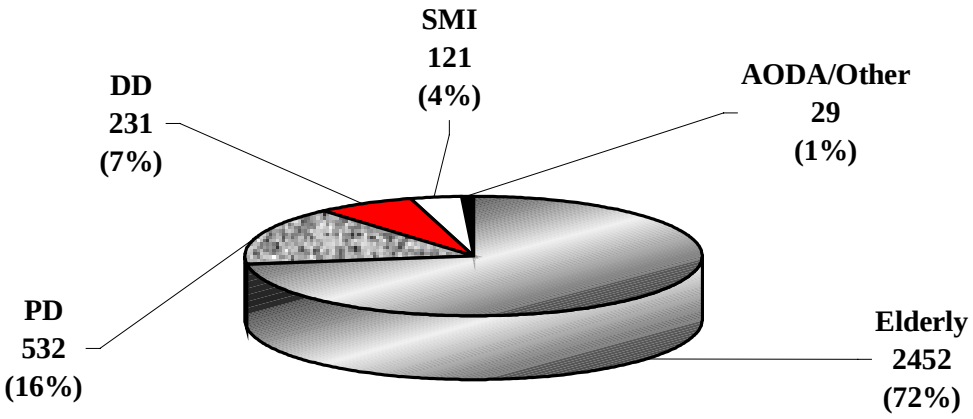
Year	Assessments	Care Plans	New Persons Served During Calendar Year	Total People Served During Calendar Year	Ratio of New Persons to Total Served
1982	712	366	198	198	100%
1983	4,399	2,836	1,399	1,549	90%
1984	6,213	3,893	2,663	3,863	69%
1985	6,674	3,883	2,585	5,233	49%
1986	8,514	4,868	2,954	6,588	45%
1987	7,632	4,998	2,573	7,414	35%
1988	6,754	4,790	2,691	8,202	33%
1989	7,198	5,125	2,939	8,372	35%
1990	8,070	5,744	3,639	10,464	35%
1991	8,301	5,699	3,613	11,320	32%
1992	8,206	5,803	3,470	11,788	29%
1993	9,876	7,348	4,102	13,173	31%
1994	9,288	6,852	3,727	13,600	27%
1995	9,548	7,070	5,113	15,103	34%
1996	9,397	6,662	5,617	16,733	34%
1997	10,539	8,462	5,953	17,062	35%
1998	11,708	9,304	5,028	17,953	28%
1999	11,889	8,226	4,456	17,976	25%
2000	9,933	5,566	3,852	17,127	22%
Total	154,851	107,495	66,572	n/a	n/a

* Does not include CIP II.

NEW PERSONS

Figure 4 illustrates the target group distribution of new persons served during 2000. The majority of the new participants served in 2000 were elderly.

FIGURE 4
New Persons Receiving Services by Target Group in 2000
for COP, COP-W and CIP II*



* Clients are considered new 2000 service clients if they have 2000 services and costs and no long-term support services of any type in 1999.

PARTICIPANT TURNOVER RATE

The Community Options Program participants receive services as long as they remain eligible and continue to need services. In the past, two-thirds of COP and COP-Waiver participants received services for three years or less. The other one-third of program participants are longer-term participants, receiving services for as long as ten years.

Turnover is defined as the number of new participants who need to be added in order to keep the caseload constant. For example, a local program may need to serve 125 persons during a year to maintain an average ongoing caseload of 100, and would have had a turnover of 25 participants. The turnover rate equals the amount of turnover divided by the total caseload. In this example, the turnover rate is 25%.

Table 4 illustrates the number of cases closed during 2000 divided by the caseload size on December 31, 2000 for each target group for COP, COP-W and CIP II. The bottom line of the table shows the turnover rate for each target group. (The "other" category reflects reporting errors which are corrected by January 1, 2001.)

TABLE 4
Calculation of Turnover by Target Group – COP, COP-W and CIP II

	Elderly	PD	DD	MI	AODA	Other	Total
All Persons Served During 2000	11,877	3,515	2,641	1,002	19	41	19,095
Point-in-Time Number of Persons Served on December 31, 2000	8,835	2,918	2,332	921	16	26	15,048
Number of Cases Closed during 2000 (Turnover)	1,903	495	111	124	0	55	2,688
Point-in Time Number of Persons Served on December 31, 1999 (Caseload size)	9,837	3,248	2,487	999	16	9	16,596
Turnover Rate	**19%**	**15%**	**4%**	**12%**	**0%**	**n/a**	**16%**

PARTICIPANT CASE CLOSURES

Table 5 illustrates the number of participants in each target group who either died, moved, transferred into the Partnership Program, are no longer income eligible or who voluntarily ended their services during 2000. Approximately 14% of all participants' cases were closed during 2000. About 45% of elderly case closures and 44% of closures of persons with physical disabilities were due to death. Approximately 36% of all cases that were closed were due to moving to an institution. Of the elderly cases closed, 42% were due to moving to an institution.

TABLE 5
Reasons for Participant Case Closures – COP, COP-W and CIP II

	Elderly	PD	DD	SMI	AODA	Other	Total
Person Died	861	217	36	19	0	18	1,151
Moved to Hospital/Nursing Facility or Other Institution	790	106	25	14	0	25	960
Transferred to Partnership Program	4	3	0	1	0	0	8
No Longer Income or Care Level Eligible	43	29	2	7	0	2	83
Voluntarily Ended Services	110	65	23	63	0	8	269
Moved	94	75	22	20	0	1	212
Other	1	0	3	0	0	1	5
Total Case Closed (all reasons)	**1,903**	**495**	**111**	**124**	**0**	**55**	**2,688**

SIGNIFICANT PROPORTIONS AND TARGET GROUPS SERVED WITH COP AND COP-W FUNDS

Community Options Program and COP-Waiver are intended to serve persons in need of long-term support at an institutional level of care. State statutes require that COP/COP-W serve persons from the major target groups in proportions that approximate the percentages of Medicaid-eligible persons who are served in nursing homes or state institutions. These percentages are called "significant proportions".

The minimum percentages for significant proportions were initially set in 1984. (The percentage for elderly has been set lower than the actual population, to allow some county flexibility.) These minimum percentages have been periodically adjusted to reflect changes in the growth of the long-term care population. The total minimum percentages add up to 84.2% with 15.8% reserved for county discretion.

TABLE 6
Significant Proportions and Target Groups

Year	Elderly	PD	DD[1]	SMI	AODA	Other	Total
	7,972	2,062	3,155	993	23	0	**14,205**
2000[2]	56.1%	14.5%	22.2%	7.0%	0.2%	0%	100%
	8,875	2,306	3,221	1,068	25	0	**15,495**
1999[2]	57.3%	14.9%	20.8%	6.9%	0.2%	0%	100%
	8,602	2,382	3,061	1,119	27	233	**15,424**
1998[2]	55.8%	15.4%	19.8%	7.3%	0.2%	1.5%	100%
	8,185	2,025	2,792	1,053	30	261	**14,346**
1997[2]	57.1%	14.1%	19.5%	7.3%	0.2%	1.8%	100%
	7,695	1,829	2,594	988	40	212	**13,358**
1996[2]	57.6%	13.7%	19.4%	7.4%	0.3%	1.6	100%
Minimum Percentages	**57.0%**	**6.6%**	**14.0%**	**6.6%**	**0%**		

1. Calculations include the use of COP-Regular funds for services above the CIP I rate.
2. Unduplicated count of persons with services funded by COP-Regular, COP-W, or CIP IB where COP is used to provide the local match.

PARTICIPANT DEMOGRAPHIC AND SERVICE PROFILES

In 2000, Community Integration Program II and COP-Waiver provided funding for home and community-based services to 13,546 elderly and persons with physical disabilities with long-term care needs. Since 1991, the census of persons served has increased on average 13.1% annually due to increases in federal and state funds.

TABLE 7
CIP II and COP-W Program Growth

Year	CIP II & COP-W Participants	Growth from Previous Year
1991	5,501	+ 34.9%
1992	6,129	+ 11.4%
1993	7,625	+ 24.4%
1994	8,326	+ 9.2%
1995	9,369	+ 12.5%
1996	10,670	+ 13.9%
1997	11,791	+ 10.5%
1998	12,895	+ 9.4%
1999	13,900	+ 7.8%
2000	13,546	- 2.5%

TABLE 8
COP, COP-W and CIP II Participants by Age
(Does not include CIP I)

AGE	NUMBER	PERCENT
Under 18 years	491	2.6
18 – 64 years	7,094	37.1
65 – 74 years	3,576	18.7
75 – 84 years	4,450	23.3
85 years and over	3,509	18.4

TABLE 9
COP, COP-W and CIP II Participants by Gender
(Does not include CIP I)

GENDER	NUMBER	PERCENT
Female	12,731	66.6
Male	6,389	33.4

TABLE 10
COP, COP-W and CIP II Participants by Race/Ethnic Background
(Does not include CIP I)

RACE/ETHNIC BACKGROUND	NUMBER	PERCENT
Caucasian	16,454	86.1
African American	1,904	10.0
Hispanic	303	1.6
American Indian/Alaska Native	243	1.3
Asian/Pacific Islander	216	1.1

TABLE 11
COP, COP-W and CIP II Participants by Marital Status
(Does not include CIP I)

MARITAL STATUS	NUMBER	PERCENT
Widow/Widower	6,035	31.6
Never Married	5,943	31.1
Married	3,512	18.4
Divorced/Separated	3,071	16.1
Unknown	559	2.9

TABLE 12
COP, COP-W and CIP II Participants by Target Group
(Does not include CIP I)

TARGET GROUP	NUMBER	PERCENT
Elderly	11,535	60.3
Physically Disabled	3,414	17.9
Developmentally Disabled	2,755	14.4
Severe Mental Illness	1,116	5.8
AODA/Other	300	1.6

TABLE 13
COP, COP-W and CIP II Participants by Natural Support Source
(Does not include CIP I)

NATURAL SUPPORT SOURCE	NUMBER	PERCENT
Adult Child	5,973	31.2
Non-Relative	2,999	15.7
Spouse	2,756	14.4
Parent	2,681	14.0
Other Relative	2,689	14.1
No Primary Support	2,021	10.6
Unknown	1	0.0

TABLE 14
COP, COP-W and CIP II Participants by Level of Care
(Does not include CIP I)

LEVEL OF CARE	NUMBER	PERCENT
Intermediate Care	9,970	52.1
Skilled Care	5,143	26.9
Mental Illness Diagnosis	453	2.4
Developmental Disability – Level 2	2,872	15.0
Developmental Disability – Level 1	442	2.3
Developmental Disability – Level 3	65	0.3
Alzheimer's Disease or Related Diagnosis	94	0.5
Grandfathered or Ongoing Since 1-1-86	28	0.1
Lost Eligibility Due to Level of Care	29	0.2
Brain Injury	24	0.1

TABLE 15
COP, COP-W and CIP II Participants who Relocated/Diverted from Institution
(Does not include CIP I)

RELOCATED/DIVERTED	NUMBER	PERCENT
Diverted from Entering any Institution	17,493	91.5
Relocated from General Nursing Home	1,289	6.7
Relocated from ICF/MR	296	1.5
Relocated from Brain Injury Rehab Unit	42	0.2

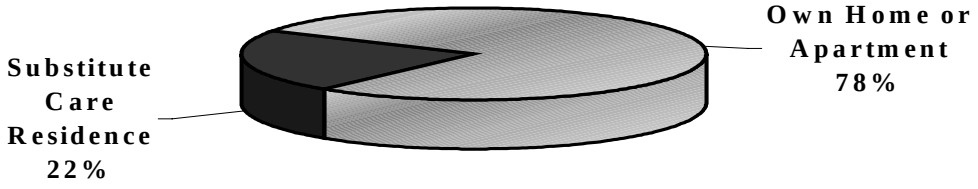
TABLE 16
COP, COP-W and CIP II Participants by Living Arrangement
(Does not include CIP I)

LIVING ARRANGEMENT	NUMBER	PERCENT
Living with Immediate Family	6,255	32.7
Living Alone	6,125	32.0
Living with Others with Attendant Care	2,431	12.7
Living with Others	1,906	10.0
Living Alone with Attendant Care	1,222	6.4
Living with Immediate Family with Attendant Care	842	4.4
Living with Extended Family	258	1.3
Living with Extended Family with Attendant Care	63	0.3
Transient Housing Situation	17	0.1
Unknown	1	0.0

TABLE 17
COP, COP-W and CIP II Participants by Type of Residence
(Does not include CIP I)

TYPE OF RESIDENCE	NUMBER	PERCENT
Own Home or Apartment	14,883	77.8
Community Based Residential Facility (CBRF)	2,473	12.9
Adult Family Home	985	5.2
Other	69	0.4
Supervised Community Living	286	1.5
Residential Care Centers for Youth & Children (RCC)	292	1.5
Residential Care Apartment Complex (RCAC)	132	0.7

FIGURE 5
Percentage of Participants in Own Home or Substitute Care Residence



PUBLIC COP AND ALL HOME COMMUNITY-BASED WAIVER FUNDING OF COMMUNITY LONG-TERM CARE BY TARGET GROUP

A total of $402,703,501 (federal waiver and state funds) was spent in 2000 on Community Options and all long-term care Medicaid Home and Community-Based Waivers. As a publicly-funded and managed program for community long-term care, COP-Regular contributes about 17% of the overall total. COP-Regular and COP-Waiver together contribute 37% of the overall total. [These figures do not include funds spent under the regular (non-waiver) Medicaid program.]

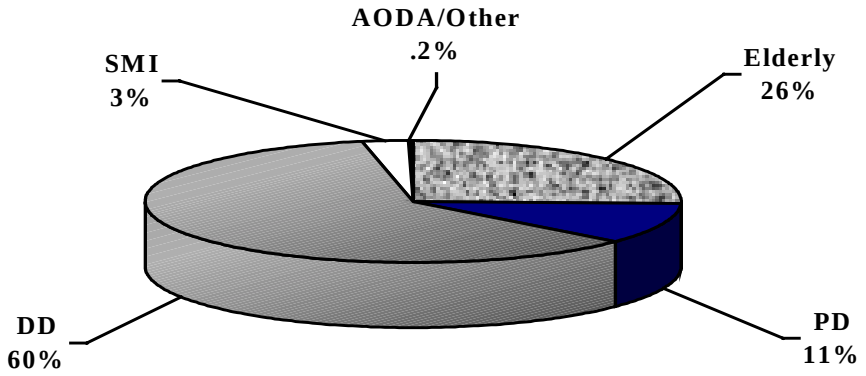
TABLE 18
Public Funding of Community Long-Term Care by Target Group

Target Group	COP-Regular	COP-W	Subtotal COP-Regular, COP-W	CIP II	Subtotal COP-Regular, COP-W, CIP II	CIP 1, CLSA, BIW	GRAND TOTAL
Elderly	24,928,925 35.9%	62,038,317 76.8%	**86,967,242 57.9%**	16,470,416 45.6%	**103,437,658 55.5%**		**103,437,658 25.7%**
PD	4,875,750 7.0%	18,740,742 23.2%	**23,616,492 15.7%**	19,648,923 54.4%	**43,265,415 23.2%**		**43,265,415 10.7%**
DD	27,342,884 39.4%		**27,342,884 18.2%**		**27,342,884 14.7%**	216,426,479 100%	**243,769,363 60.5%**
SMI	11,624,759 16.8%		**11,624,759 7.7%**		**11,624,759 6.2%**		**11,624,759 2.9%**
AODA	276,347 .4%		**276,347 .2%**		**276,347 .1%**		**276,347 .1%**
Other	329,959 .5%		**329,959 .2%**		**329,959 .2%**		**329,959 .1%**
Total	**69,378,624 17.2%**	**80,779,059 20.1%**	**150,157,683 37.3%**	**36,119,339 9.0%**	**186,277,022 46.3%**	**216,426,479 53.7%**	**402,703,501 100.0%**

Source: Reconciliation schedules

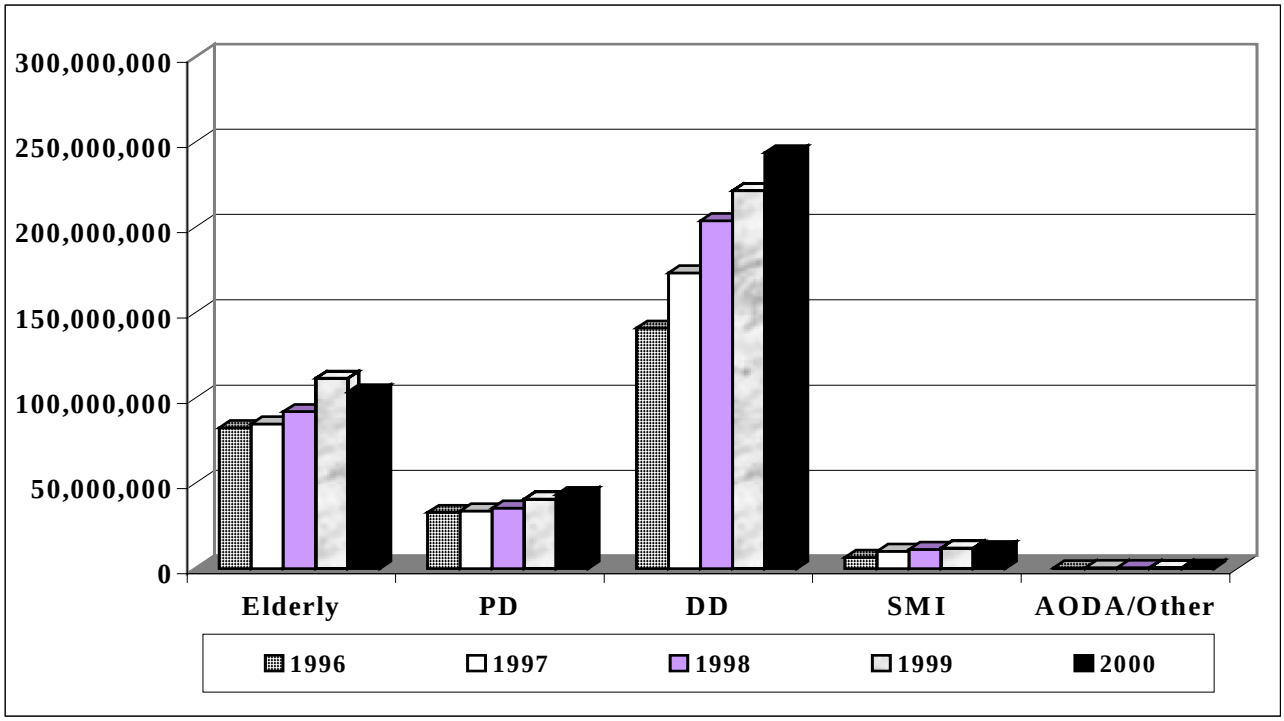
- The elderly received 26% of the funds;
- persons with physical disabilities (PD) received 11% of the funds;
- persons with developmental disabilities (DD) received 60% of the funds;
- persons with severe mental illness (SMI) received 3% of the funds; and
- persons with alcohol and/or drug abuse (AODA) or other conditions received less than 1% of the funds.

FIGURE 6
Total COP and Waivers Spending by Target Group



Services for participants are grouped by client characteristics (Figure 7). The "elderly" category includes all persons age 65 or older regardless of type of disability. All other participants are younger than 65. All participants have a need for a level of care equivalent to a nursing home care level.

FIGURE 7
Public Funding for Community Long-Term Care by Target Group
1996 – 2000



COP-REGULAR

Community Options Program (COP-Regular) general purpose revenue (GPR) is used in the following ways:

- 36% of the total COP funds were used for services for COP only participants;
- 39% were used as match to increase services to waiver eligible people by creating more waiver slots;
- 10% were used for current waiver participants to provide services that could not be paid for with waiver funds;
- 11% were used for administrative costs, and 50% of the total funds utilized for administration were for special projects and for the establishment of COP risk reserves at the county level. The establishment of these reserves accounted for 2% of all COP funds reimbursed;
- 9% were used to cover the matching share of expenses for those participants whose cost of care exceeds the waiver allowable rates (exceptionally high cost individuals);
- 3% of COP-Regular funds were used to conduct assessments and develop care plans for COP and Medicaid waiver eligible people.

In calendar year 2000, $6,142,488 COP-Regular (GPR) dollars were used to fund the match for CIP 1 so those counties could earn additional federal funds for persons who were elderly and/or developmentally disabled, and the average counties' costs exceeded the allowable reimbursement rate. When COP funding is used in this way it is referred to as "overmatch". In addition, $89,808 of COP-Regular (GPR) dollars were used to fund the match for CIP II so those counties could earn additional federal funds for persons who were elderly and/or physically disabled, and the average counties' costs exceeded the allowable reimbursement rate. Another $3,351,469 of COP-Regular funds were used as match to expand the COP-W program.

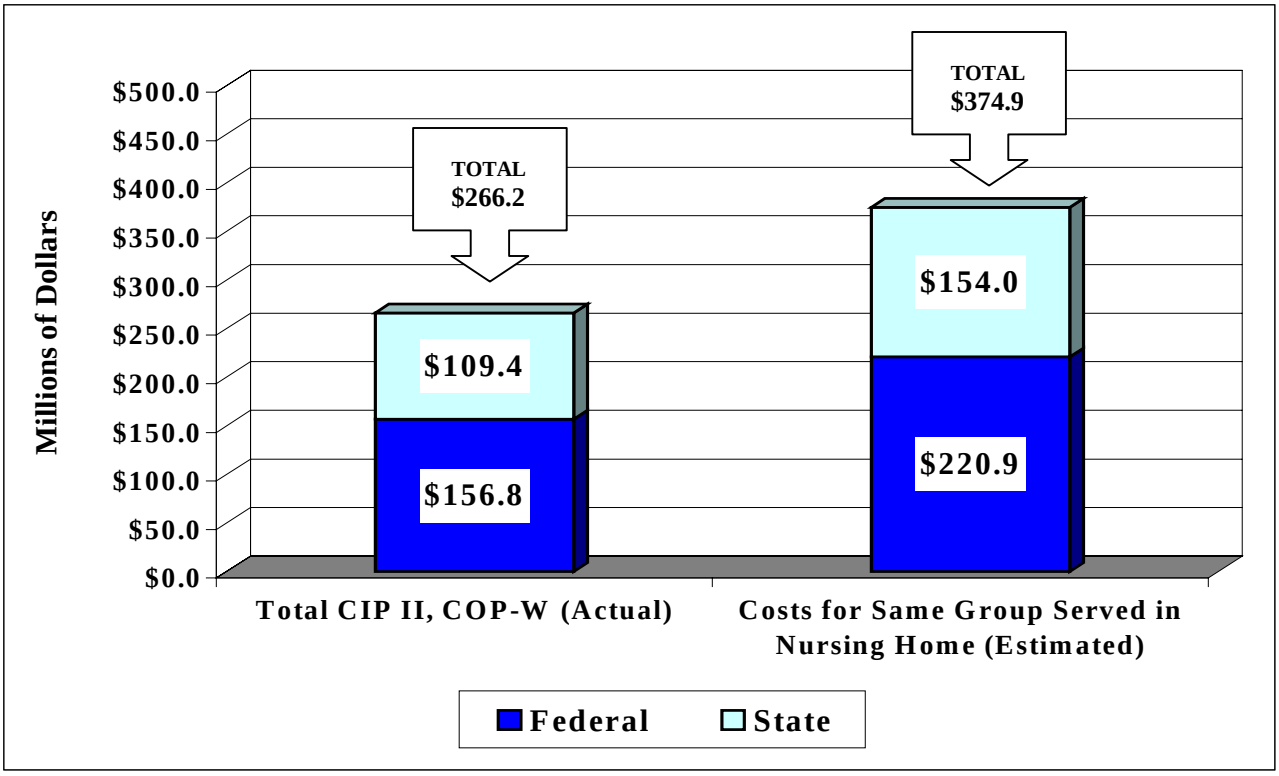
MEDICAID NURSING HOME USE

The Community Options Program and the Medicaid Home and Community-Based Waivers have made possible a lower utilization of nursing home beds by Medicaid participants in Wisconsin. At the same time, COP also filled the gaps in unpaid care provided by family and friends. The extra support services paid for by COP reduce the burden on families who provide substantial amounts of unpaid care. COP has enabled people with long-term care needs to continue to live in their own homes and communities. COP has also been a stimulus to the growth of community care providers in the private sector. Since the beginning of COP and the development of alternatives to nursing home care, days of care paid for by Medicaid in nursing homes have declined. Also, in 2000, CIP II expanded by 222 slots.

COMPARING COP-W PARTICIPANTS' COSTS TO THEIR COSTS IF THEY WOULD HAVE RECEIVED NURSING HOME CARE

Figure 8 illustrates the public costs for participants served with CIP II & COP-Waiver, and compares Medicaid costs for these same participants if they would have been served in a nursing home. The total state and federal costs are compared below if the participants, at the same level of care, were served in a nursing home.

FIGURE 8
Actual Annual 2000 CIP II and COP-W Costs vs. Estimated Care in Nursing Home



The management, monitoring and attention to program cost effectiveness for COP and COP-W are carried out in a number of ways. For additional information on costs of care in the community and in nursing homes, see Table 24 on Page 20.

COP FUNDING FOR EXCEPTIONAL NEEDS

The statewide Community Options Program fund for exceptional needs is part of COP. The Department may carry forward to the next fiscal year, COP and COP-W GPR funds allocated but not spent by December 31, statute 46.27(7)(g). These exceptional funds may be allocated for the improvement or expansion of long-term community support services for clients. Services may include:

a) start-up costs for developing needed services for eligible target groups;

b) home modifications for COP eligible participants and housing funding;

c) purchase of medical services and medical equipment or other specially adapted equipment;

d) vehicle modifications; and

e) dental work.

In 2000, funding for exceptional needs was awarded to 43 counties. Examples of individual awards include "homecoming" funds to enable people to move from an institution to the community such as furnishings, making security deposits, etc. Awards were made for home modifications such as mobility lifts, overhead track lifts, roll-in showers, raised toilets, lowered cabinets and fixtures, grab bars, wider hallways and doors, door openers, automatic controls for windows, lights, temperature, adapted beds, adapted chairs, etc. Awards were also made for adapted mobility equipment such as wheelchairs and scooters not covered by Medicaid, as well as van modifications.

COP-REGULAR AND COP-W EXPENDITURES

Table 19 (next page) illustrates statewide expenditures and reimbursement of Community Options Program funds for the calendar years 1982 through 2000. Lead agencies are reimbursed at a fixed rate for each assessment and each care plan completed for participants in COP or by any of Wisconsin's Medicaid Home and Community-Based Waivers.

Table 19 also illustrates service funds expended and reimbursed for persons through either COP-Regular or COP-Waiver. This includes COP funds used as match for federally-funded CIP I or CSLA. The COP-W and locally matched CIP I/CSLA service funds are further broken out into the state GPR and federal share of service costs. Table 19 includes the portion of federal funds generated when COP is used as a matching source for CIP I or CSLA locally matched slots. It does not include the federal funds associated with CIP I slots which are funded by state and federal Medicaid dollars (fully funded slots).

NOTES FOR TABLE 19 – COP-REGULAR AND COP-W EXPENDITURES

Column 1: Total costs reported by lead agencies for COP, COP-W and CIP I where COP is used as match.

Column 2: COP funds paid for assessments and care plans. Includes federal assessment funds in 1987-1989.

Column 3: COP funds paid for COP-Regular services. Includes service funds expended for local program administration and COP Alzheimer Service funds.

Column 4: The GPR (state match) portion paid for federally-funded COP-W services.

Column 5: The total amount of GPR funds paid (total of columns 2, 3 and 4).

Column 6: The federal portion of funds paid for COP-W services.

Column 7: The federal portion of funds paid for CIP II, CIP I or CSLA services for which COP funds were used as the state/local match or overmatch. Counties may have additional state and federal revenue for fully funded CIP I or CSLA slots, or for slots matched with local funds other than COP.

Column 8: Includes other federal revenue and revenue for Medicaid-funded case management available to offset state reimbursement of reported costs. Additional revenue may have been applied to reduce county overmatch for costs incurred above the COP contract level. Also includes revenue generated by a county that charges participants for assessment and plan costs.

Column 9: The total amount of federal funds paid (total of columns 6, 7 and 8).

Column 10: The amount listed is assumed to be local Community Aids, county overmatch or other revenue used for COP services based on differences between amounts reported on HSRS and payments amounts.

Column 11: Total paid from all sources (total of columns 5, 9 and 10).

TABLE 19
COP-Regular and COP-W Expenditures

1	2	3	4	5	6	7	8	9	10	11
	Community Options GPR Funds Paid				Federal Funds Paid (matched with COP-Regular fund)					
Year and Total Costs Reported	Assess. and Plans	COP-Regular Services	COP-W GPR Services	Total GPR Paid	COP-W Fed. Paid	CIP II/CIP1 Fed Overage & CIP 1B Fed Match Paid	Other Fed Revenue	Total Fed Paid	Comm. Aids, Overmatch, or Other	Grand Total Paid
2000										
185,469,882	2,159,343	67,219,281	30,296,720	99,675,344	50,482,339	34,098,842	436,354	85,017,535	777,003	185,469,882
1999										
188,779,088	3,076,096	66,662,899	32,132,870	101,871,865	49,257,778	35,321,774	492,151	85,071,703	1,835,520	188,779,088
1998										
167,320,607	2,854,106	63,627,776	26,181,427	92,663,309	42,441,290	30,044,574	516,841	73,002,705	1,654,593	167,320,607
1997										
149,260,716	2,556,110	59,819,203	22,634,789	85,010,102	38,098,122	24,629,387	493,662	63,221,171	1,029,443	149,260,716
1996										
131,974,493	2,194,049	57,948,468	20,997,816	81,140,333	32,170,998	17,183,765	620,566	49,975,329	858,831	131,974,493
1995										
115,684,575	2,264,528	55,507,478	18,057,357	75,829,363	27,550,760	10,863,905	679,487	39,094,152	761,060	115,684,575
1994										
96,792,770	2,009,347	47,806,015	15,075,439	64,890,801	24,085,246	5,492,128	723,866	30,301,240	1,600,729	96,792,770
1993										
83,982,322	2,179,975	44,444,357	13,310,325	59,934,657	20,329,641	1,984,764	673,045	22,987,450	1,060,215	83,982,322
1992										
66,965,400	1,778,355	40,222,689	8,082,092	50,083,136	13,426,855	1,404,418	741,861	15,573,134	1,309,130	66,965,400
1991										
57,295,820	1,481,325	35,818,495	6,867,305	44,167,125	10,939,142	249,841	880,168	12,069,151	1,059,544	57,295,820
1990										
46,825,507	1,619,224	33,758,085	4,312,550	39,689,859	6,322,549		562,287	6,884,836	250,812	46,825,507
1989										
37,172,208	1,353,769	29,931,012	1,962,392	33,247,173	2,873,078		467,675	3,340,753	584,282	37,172,208
1988										
29,921,032	1,263,683	27,738,371	2,678	29,004,912	406,796		441,113	847,909	68,211	29,921,032
1987										
26,648,810	1,451,918	24,832,371		26,234,289				414,520		26,648,809
1986										
20,766,847	1,365,906	19,400,941		20,766,847						20,766,847
1985										
16,083,729	1,875,085	14,108,644		16,083,729						16,083,729
1984										
10,074,947	1,238,231	8,836,716		10,074,947						10,074,947
1983										
3,315,127	832,116	2,483,011		3,315,127						3,315,127
1982										
309,501	110,920	198,581		309,501						309,501

Source: Reconciliation schedules

COP FUNDS USED FOR PARTICIPANTS WITH ALZHEIMER'S AND RELATED DEMENTIAS

The Community Options Program was changed in 1986 to target some funding for persons with Alzheimer's disease or related dementias who would not otherwise meet level of care eligibility requirements. In the first few years following this change, not all funds allocated for this purpose were spent. Alzheimer's disease was difficult to diagnose at that time. Subsequently, eligibility for these funds was extended to all persons with an Alzheimer's or related diagnosis, regardless of level of care. Beginning in 1996, the special COP Alzheimer's funds were no longer kept separate from COP-Regular funds and counties were no longer required to track this allocation separately. In 2000, a total of 507 participants were reported on HSRS as having an Alzheimer's or related dementia diagnosis. Of these individuals, 448 were functionally eligible for COP, 59 were reported as eligible only by diagnosis, not by level of care.

Table 20 summarizes the use of these legislatively targeted funds, plus additional COP-Regular funds spent for this participant group.

TABLE 20
Use of COP-Regular Alzheimer's Funds
Includes Other Related Dementias such as Friedrich's Ataxia, Huntington's Disease, and Parkinson's Disease

Year	Allocation	Unspent Carryover	Not Meeting LOC[1] Eligibility		Meeting LOC Eligibility		Total Expenditures
			Persons[5]	Expenditures[2]	Persons[5]	Expenditures[2]	
2000	990,993	n/a	59	607,121	448	2,869,304	3,476,425
1999	990,993	n/a	66	643,331	431	2,895,134	3,538,465
1998	990,993	n/a	71	647,269	408	2,688,560	3,335,829
1997	990,993	n/a	90	761,457	380	2,357,809	3,119,266
1996	990,993	n/a	171	1,934,930	312	1,287,275	3,222,205
1995	990,993	67,780	193	1,366,978	382	2,240,516	3,607,494
1994	990,993	0	227	1,477,554	317	1,779,178	3,256,732
1993	990,993	0	247	1,523,806	303	1,346,908	2,870,714
1992	990,993	0	258	1,367,453	261	963,633	2,331,086
1991	990,993	0	267	1,276,261	219	809,499	2,085,760
1990	990,993	0	264	1,158,684	257	723,914	1,882,598
1989	1,004,975	150,777	290	854,198	249	603,357	1,457,555
1988	1,028,003	334,356	229	693,647	190	479,978	1,173,625
1987	759,785	362,307	177	397,478	158	416,608	814,086
1986	499,999	n/a[3]	94	194,761	n/a[4]	n/a[4]	194,767

Source: HSRS COP Alzheimer's Report and Allocation Tables (The above table does not include those participants who receive Medicaid waiver funding only.) Some participants who receive waiver funding, as well as COP-Regular, may be included above.

1. LOC stands for level of care.
2. All COP funds including special COP Alzheimer's allocation.
3. Funds could not be carried over prior to 1987.
4. Because there was no HSRS code for persons with Alzheimer's disease or related dementias prior to 1987, the number of persons with these conditions who met level of care eligibility and COP expenditures could not be determined.
5. In many cases, counties might not report Alzheimer's as one of the client's reported characteristics. Therefore, the number of individuals with an actual Alzheimer's diagnosis may be greater than the number reported here.

In 2000, 325 participants served with Medicaid waiver funds were reported with a secondary diagnosis of Alzheimer's or a related dementia. The total expenditures for those participants were $3,213,395. These waiver participants and expenditures are not included in the above table.

CIP II AND COP-W SERVICES

Community Integration Program II and COP-Waiver participants utilize services federally authorized through its Medicaid waiver application and services traditionally available to all Medicaid recipients through the state's Medicaid Plan (e.g., card services). State Medicaid Plan services are provided to all Medicaid recipients eligible for a Medicaid card. The Medicaid Plan services are generally for acute medical care. Waiver services are generally non-medical in nature. Since both types of services are needed to maintain individuals in the community, expenditures for both types must be combined to determine the total public cost of serving waiver participants.

State statutes require use of Medicaid waiver funds only for expenses not covered in the Medicaid program. The waiver services provided, their rate of utilization, and the total costs for each service are outlined in the table below. The total cost of Medicaid fee for service card costs for these waiver participants was $110,600,338.

TABLE 21
Total 2000 Medicaid State Plan and Waiver Costs for CIP II and COP-W

Total CIP II and COP-W Service Costs	$120,339,680
Total Medicaid Card Service Costs for CIP II and COP-W Recipients	$110,600,338
Total 2000 Medicaid Expenditures for CIP II and COP-W Recipients	**$230,940,018**

Costs of care, services and environmental adaptations for waiver participants are always a combination of Medicaid State Plan benefits and waiver benefits. The coordination of benefits across the program is a key component of the Community Options Program and the waivers.

TABLE 22
2000 Utilization of Waiver Services by CIP II and COP-W Participants

CIP II and COP-W Medicaid Service Categories	Rate of Participant Utilization (%)	Cost	Percent of Total Waiver Costs
Care Management	97.29	$15,039,333	12.50
Supportive Home Care/Personal Care	88.77	58,354,408	48.49
Adult Family Home	4.10	7,187,104	5.97
Residential Care Apartment Complex	1.55	2,260,258	1.88
Community Based Residential Facility	9.39	18,550,091	15.41
Respite Care	4.19	1,631,465	1.36
Adult Day Care	7.35	4,174,565	3.47
Day Services	1.16	826,732	0.69
Daily Living Skills Training	1.60	1,572,111	1.31
Counseling and Therapies	10.59	592,900	.49
Skilled Nursing	1.69	120,431	.10
Transportation	20.61	2,296,285	1.91
Personal Emergency Response System	36.79	1,264,492	1.05
Adaptive Equipment	14.62	1,622,463	1.35
Communication Aids	2.30	88,749	0.07
Medical Supplies	15.42	886,603	0.74
Home Modifications	3.93	1,167,125	0.97
Home Delivered Meals	25.02	2,704,565	2.25
Total Medicaid Waiver Service Costs		**$120,339,680**	

Note: Totals may not equal 100% due to rounding.

TABLE 23
2000 Utilization of Medicaid State Plan (Card) Benefits
by CIP II and COP-W Participants

Medicaid State Plan Benefits Categories	Rate of Participant Utilization (%)	Cost	Percent of Total Card Costs
Inpatient Hospital	3.3	$5,469,633	4.9
Physician (Physician Services, Clinic Services – including outpatient Mental Health)	70.8	3,287,591	3.0
Outpatient Hospital	51.9	3,575,622	3.2
Lab and X-ray	57.2	653,878	0.6
Prescription Drugs	91.9	31,319,383	28.3
Transportation (Ambulance and Non-Emergency Specialized Motor Vehicle)	53.2	3,680,382	3.3
Therapies (Physical Therapy, Speech and Hearing Therapy, Occupational Therapy, Restorative Care Therapy, Rehabilitative Therapy)	45.5	12,505,110	11.3
Dental Services	17.3	540,271	0.5
Nursing (Nurse Practitioner, Nursing Services)	0.2	516,487	0.5
Home Health, Supplies & Equipment (Home Health Therapy, Home Health Aide, Home Health Nursing, Enteral Nutrition, Disposable Supplies, Other Durable Medical Equipment, Hearing Aids)	64.0	16,688,781	15.1
Personal Care (Personal Care, Personal Care Supervisory Services)	34.5	31,508,643	28.5
All Other (Other Practitioners Services, Family Planning Services, HealthCheck/EPDST, Rural Health Clinic Services, Home Health Private Duty Nursing – Vent, Other Care, Hospice, Community Support Program)	3.6	854,557	0.8
Total Medicaid State Plan Benefit Costs for Waiver Recipients		**$110,600,338**	

Notes: Totals may not equal 100% due to rounding. In 1996, Wisconsin Medicaid restructured CIP II and COP-W Medicaid card service reporting to comply with changes in federal Medicaid reporting requirements.

PUBLIC FUNDING AND COST COMPARISON OF MEDICAID WAIVER AND MEDICAID NURSING HOME CARE

In addition to Medicaid-funded services, many waiver participants receive other public funds that can be used to help pay for long-term care costs. To provide an adequate comparison of the cost of serving persons through the Medicaid waiver versus the cost of meeting individuals' long-term support needs in nursing homes; an analysis of total public funding used by each group was completed.

Table 24 below indicates total public funds spent per capita on an average daily basis for nursing home and waiver care. It also indicates the breakdown between federal spending and state and/or county spending for each funding source.

TABLE 24
2000 Average Public Costs for
CIP II & COP-W Participants vs. Nursing Home Residents
Average Cost per Person per Day

Year	Cost Category	Community Care Costs			Nursing Home Costs[1]			Difference		
		Total	State / County	Federal	Total	State / County	Federal	Total	State / County	Federal
2000	Medicaid Program Per Diem	$29.01	$11.92	$17.09	$79.44	$32.64	$46.80			
	Medicaid Card	26.66	10.96	15.70	10.82	4.45	6.37			
	Medicaid Costs Subtotal[2]	$55.67	$22.88	$32.79	$90.26	$37.09	$53.17	$34.59	$14.21	$20.38
	COP – Services w/Admin.	1.54	1.54	0.00	n/a[3]	n/a[3]	n/a[3]			
	COP – Assessments & Plans	0.36	0.36	0.00	n/a[3]	n/a[3]	n/a[3]			
	SSI	3.42	1.41	2.01	0.12	0.00	0.12			
	Community Aids	0.04	0.02	0.02	unk.	unk.	unk.			
	Other	3.13	0.17	2.96	n/a[4]	n/a[4]	n/a[4]			
	Total	**$64.16**	**$26.38**	**$37.78**	**$90.38**	**$37.09**	**$53.29**	**$26.22**	**$10.71**	**$15.51**

When all public costs are counted, expenses for CIP II and COP-W participants averaged $64.16 per person per day in 2000, compared to $90.38 per day for Medicaid recipients in nursing facilities. On average, then, the per capita daily cost of care in CIP II and COP-W during 2000 was $26.22 less than the cost of nursing home care, compared to a difference of $28.20 in 1999.

TABLE 25
1999 Average Public Costs for
CIP II & COP-W Participants vs. Nursing Home Residents
Average Cost per Person per Day

Year	Cost Category	Community Care Costs			Nursing Home Costs[1]			Difference		
		Total	State / County	Federal	Total	State / County	Federal	Total	State / County	Federal
1999	Medicaid Program Per Diem	$29.89	$12.30	$17.59	$77.25	$31.80	$45.45			
	Medicaid Card	21.18	8.72	12.46	9.93	4.09	5.84			
	Medicaid Costs Subtotal[2]	$51.07	$21.02	$30.05	$87.18	$35.89	$51.29	$36.11	$14.87	$21.24
	COP – Services w/Admin.	1.74	0.72	1.02	n/a[3]	n/a[3]	n/a[3]			
	COP – Assessments & Plans	0.22	0.09	0.13	n/a[3]	n/a[3]	n/a[3]			
	SSI	4.75	1.96	2.79	0.11	0.00	0.11			
	Community Aids	0.05	0.02	0.03	unk.	unk.	unk.			
	Other	1.26	0.52	0.74	n/a[4]	n/a[4]	n/a[4]			
	Total	**$59.09**	**$24.33**	**$34.76**	**$87.29**	**$35.89**	**$51.40**	**$28.20**	**$11.56**	**$16.64**

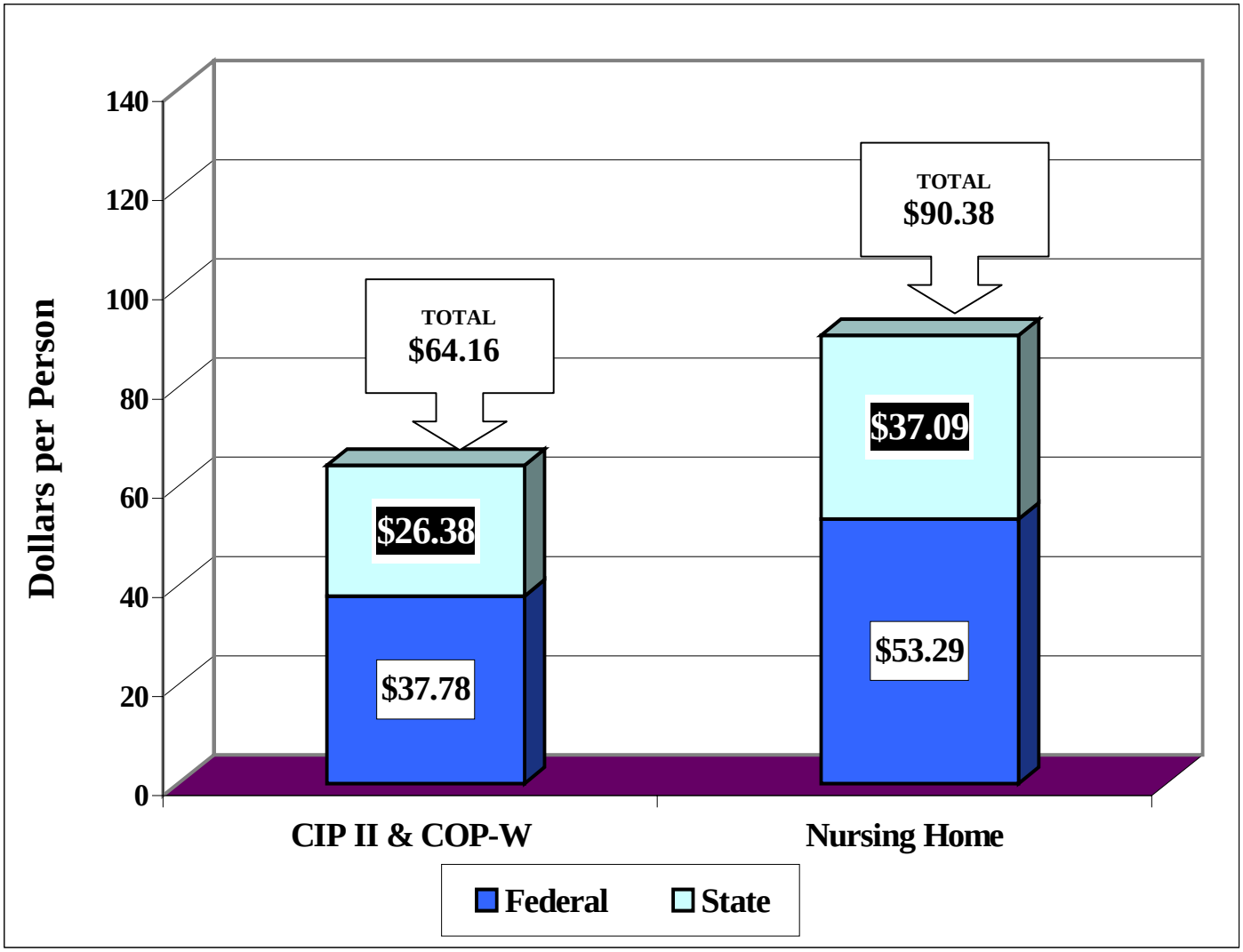
The following footnote references are for Table 24 and Table 25:

1. IMD costs are omitted from the total nursing home cost because persons who require institutionalization primarily due to a chronic mental illness are not eligible for CIP II or COP-W.
2. Medicaid reporting is subject to subsequent adjustments due to a 12-month claims processing period.
3. Nursing home residents are not eligible for the Community Options Program.
4. This category applies only to community care.

COST EFFECTIVENESS

A total of 4,148,482 service days were provided to 13,546 Community Integration Program II and COP-Waiver participants during 2000. Therefore, the total public cost of care for waiver participants in 2000, based on actual days of service, was $266,166,605 ($64.16 per day for 4,148,482 days). If the 13,546 individuals had spent the same 4,148,482 days in nursing homes at the average daily public cost for nursing home care, the total cost of serving them in 2000 would have been $374,939,803 ($90.38 per day for 4,148,482 days). The total public spending on behalf of these individuals is estimated to have been $108,773,198 less than if they had resided in nursing homes for the same length of time. Figure 9 below compares actual average daily per capita costs.

FIGURE 9
CIP II & COP-W vs. Nursing Home Care in 2000
Average Public Costs per Day



CARE LEVEL AND ITS SIGNIFICANCE FOR THE COST COMPARISONS

The cost differences evident in the previous comparisons (Table 24), while calculated using actual costs of care for waiver participants and nursing home residents, may be influenced by differences in the care needs of these two populations. In 2000, 65 percent of Community Integration Program II and COP-Waiver program participants were rated at the intermediate care facility (ICF) level and 35 percent were rated at the skilled nursing facility (SNF) level. Corresponding figures for persons residing in nursing homes during 2000 were 13 percent ICF and 87 percent SNF, based on aggregate calendar year nursing home days of care. The significance of any care level difference that exists can be determined by re-estimating average daily and total public costs after adjusting the reported care level proportions.

Based on data supplied for the Department's annual cost report to the Health Care Financing Administration, the actual 2000 nursing home Medicaid per diem for ICF residents was approximately $61.74. For SNF residents the Medicaid per diem was approximately $82.08. If the proportions of nursing home residents receiving care at the ICF and SNF levels had been equal to the proportions reported for CIP II and COP-W participants (65 percent ICF and 35 percent SNF), estimated costs to Medicaid for nursing home care would have been $658,805,659 instead of $759,998,760. Given that there were 9,567,459 Medicaid-funded days of nursing care at the ICF and SNF levels combined in 2000, this level of total Medicaid spending would have translated to an average per diem across care levels of $68.86 (Table 26), instead of the previously calculated $79.44 (Table 24).

Assuming the same Medicaid card costs and other expenses, the average daily public cost of nursing home care would have been $79.80 per person (Table 26), instead of $90.38 as reported in Table 24. The difference between average daily per capita waiver costs and average nursing home costs, therefore, would have been $15.64 instead of $26.22. This represents a difference of 20 percent, compared to 29 percent. Table 26 presents the estimated daily per capita public costs and the waiver/nursing home cost comparisons shown in Table 24 after adjusting the average nursing home per diem in this manner.

Using these adjusted figures, the potential impact of waiver utilization on total public spending can be estimated as it was in the previous section. That is, if 13,546 waiver participants had spent the same 4,148,482 days residing in nursing homes, they would have incurred total public costs of $331,048,864 ($79.80 per day for 4,148,482 days), compared with the $266,166,605 they incurred while residing in the community. Assuming equivalent care level proportions, then, total public spending for COP-W/CIP II participants during 2000 was $64,882,258 less than the predicted cost of nursing home care for a comparable group. This figure is 12 percent less than the $374,939,803 estimated using actual 2000 data, but it still represents a difference in total public costs of 20 percent compared with the cost of an equivalent volume of nursing home care. This revised estimate may represent the lower boundary of the difference in costs attributable to these waivers, while the estimate based on actual costs represents an upper boundary.

TABLE 26
2000 Estimated Average Public Costs for CIP II & COP-W Participants vs. Nursing Home Residents Adjusting for Level of Care - Average Cost per Person per Day

Year	Cost Category	Community Care Costs			Nursing Home Costs*[1]			Difference		
		Total	State / County	Federal	Total	State / County	Federal	Total	State / County	Federal
2000	Medicaid Program Per Diem	$29.01	$11.92	$17.09	$68.86	$28.30	$40.56			
	Medicaid Card	26.66	10.96	15.70	10.82	4.45	6.37			
	Medicaid Costs Subtotal[2]	$55.67	$22.88	$32.79	$79.68	$32.74	$46.94	$24.01	$9.86	$14.15
	COP – Services w/Admin.	1.54	1.54	0.00	n/a[3]	n/a[3]	n/a[3]			
	COP – Assessments & Plans	0.36	0.36	0.00	n/a[3]	n/a[3]	n/a[3]			
	SSI	3.42	1.41	2.01	0.12	0.00	0.12			
	Community Aids	0.04	0.02	0.02	unk.	unk.	unk.			
	Other	3.13	0.17	2.96	n/a[4]	n/a[4]	n/a[4]			
	Total	**$64.16**	**$26.38**	**$37.78**	**$79.80**	**$32.79**	**$47.01**	**$15.64**	**$6.41**	**$9.23**

TABLE 27
1999 Estimated Average Public Costs for CIP II & COP-W Participants vs. Nursing Home Residents Adjusting for Level of Care - Average Cost per Person per Day

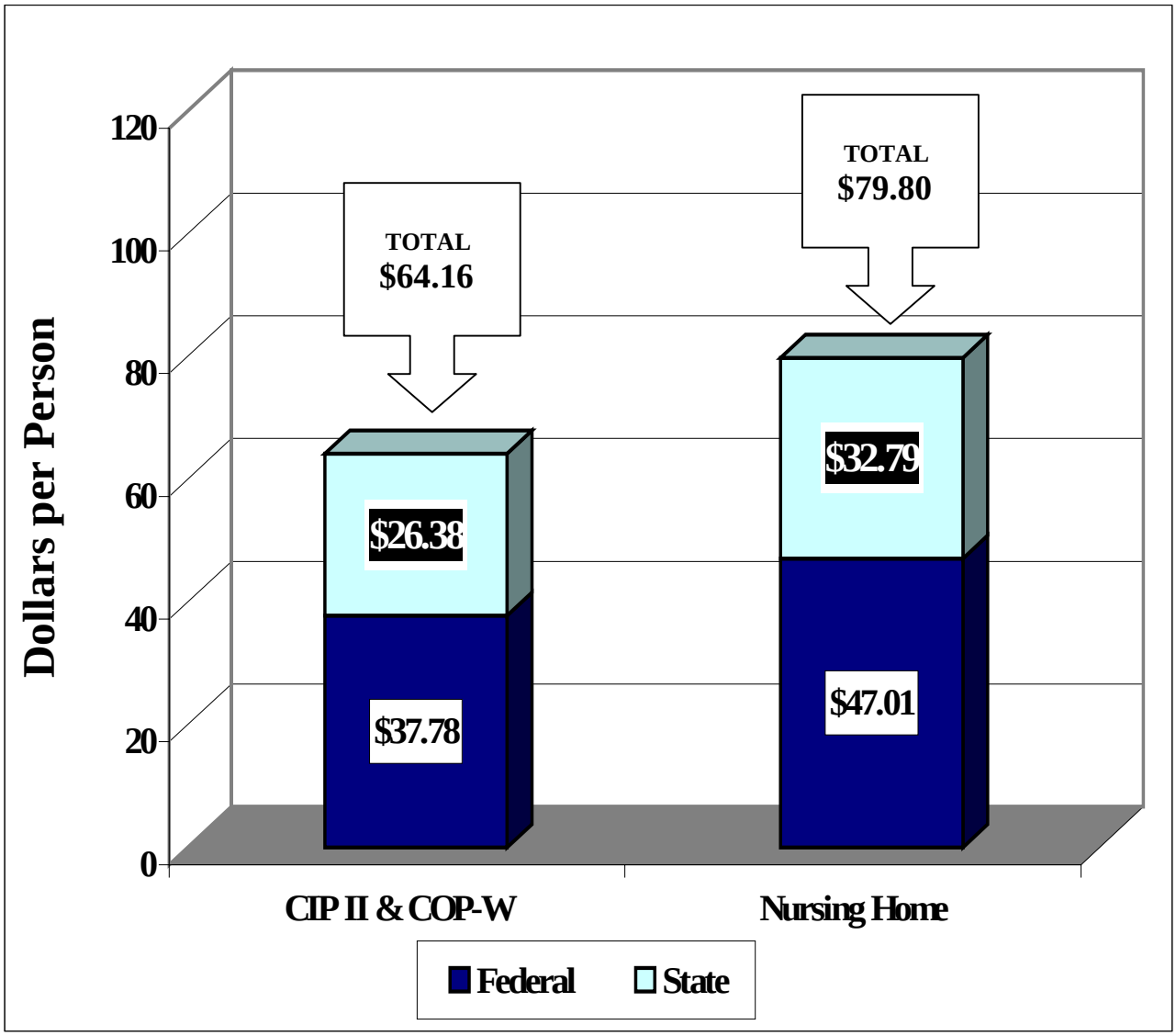
Year	Cost Category	Community Care Costs			Nursing Home Costs*[1]			Difference		
		Total	State / County	Federal	Total	State / County	Federal	Total	State / County	Federal
1999	Medicaid Program Per Diem	$29.89	$12.30	$17.59	$75.80	$31.20	$44.60			
	Medicaid Card	21.18	8.72	12.46	9.93	4.09	5.84			
	Medicaid Costs Subtotal[2]	$51.07	$21.02	$30.05	$85.73	$35.29	$50.44	$34.66	$14.27	$20.39
	COP – Services w/Admin.	1.74	0.72	1.02	n/a[3]	n/a[3]	n/a[3]			
	COP – Assessments & Plans	0.22	0.09	0.13	n/a[3]	n/a[3]	n/a[3]			
	SSI	4.75	1.96	2.79	0.11	0.00	0.11			
	Community Aids	0.05	0.02	0.03	unk.	unk.	unk.			
	Other	1.26	0.52	0.74	n/a[4]	n/a[4]	n/a[4]			
	Total	**$59.09**	**$24.33**	**$34.76**	**$85.84**	**$35.29**	**$50.55**	**$26.75**	**$10.96**	**$15.79**

The following footnote references are for Table 26 and Table 27:

* Nursing home program per diems have been calculated assuming that the proportion of residents rated at the SNF and ICF care levels was the same as that reported for Medicaid Waiver participants in each of the respective years. The figures shown thus represent not actual costs but the costs that would have been incurred had the assumed SNF/ICF proportions prevailed. In nursing homes during 2000, 13% of residents were rated at an ICF level, and 87% were SNF.

1. IMD costs are omitted from the total nursing home cost because persons who require institutionalization primarily due to a chronic mental illness are not eligible for CIP II or COP-W.
2. Medicaid reporting is subject to subsequent adjustments due to a 12-month claims processing period.
3. Nursing home residents are not eligible for the Community Options Program.
4. This category applies only to community care.

FIGURE 10
CIP II & COP-W vs. Nursing Home Care in 2000
Adjusting for Level of Care
Estimated Average Public Costs per Day



Appendix A

PERFORMANCE STANDARDS

A state leadership committee established the framework for assessing quality in the Community Options Program. In order to ensure the goals of COP are met, person-centered performance outcomes valued by COP participants are incorporated into the acronym RESPECT:

Relationships between participants, care managers and providers are based on caring, respect, continuity over time, and a sense of partnership.

Empowerment of individuals to make choices, the foundation of ethical home and community-based long-term support services, is supported.

Services that are easy to access and delivered promptly, tailored to meet unique individual circumstances and needs are provided.

Physical and mental health services are delivered in a manner that helps people achieve their optimal level of health and functioning.

Enhancement and maintenance of each participant's sense of self-worth, and community recognition of his or her value is fostered.

Community and family participation is respected and participants are supported to maintain and develop friendships and share in their families and communities.

Tools for self-determination are provided to help participants achieve maximum self-sufficiency and independence.

RESPECT performance standards are measured by the extent to which:

- care managers identify a participant's health status and care needs, create or arrange for appropriate services to support and not supplant the help available from family, friends and the community, and monitor the performance of service providers;
- services respond to individual needs;
- participant preferences and choices are honored, and the participant is satisfied with the services delivered; and most importantly,
- participants are able to maintain a home of their own choice and participate in community life.

Appendix B

DEFINITIONS OF COMMUNITY LONG-TERM CARE PROGRAMS

COMMUNITY OPTIONS PROGRAM (COP):
The Community Options Program, administered by the Department of Health and Family Services, is managed by local county agencies to deliver community-based services to Wisconsin citizens in need of long-term assistance. Any person, regardless of age, with nursing home level of care is eligible for COP. The program began as a demonstration in eight counties in 1982 and was expanded statewide in 1986.

Funding: GPR/State = 100%.

COMMUNITY OPTIONS PROGRAM-WAIVER (COP-WAIVER OR COP-W):
A Medicaid-funded waiver program which provides community services to the elderly and persons with physical disabilities who have long-term needs and who would otherwise be eligible for Medicaid reimbursement in a nursing home.

Funding: GPR/State = Approximately 40% (budgeted separately with COP GPR/state funds)
Federal = Approximately 60%

COMMUNITY INTEGRATION PROGRAM II (CIP II):
A Medicaid-funded waiver program that provides community services to the elderly and persons with physical disabilities *after a nursing home bed is closed.*

Funding: GPR/State = Approximately 40% (state Medicaid funding)
Federal = Approximately 60% (federal Medicaid funding)

COMMUNITY INTEGRATION PROGRAM IA (CIP IA):
A Medicaid-funded waiver program that provides community services to persons with developmental disabilities who are relocated from the State Centers for the Developmentally Disabled.

Funding: GPR/State = Approximately 40% (state Medicaid funding)
Federal = Approximately 60% (federal Medicaid funding)

COMMUNITY INTEGRATION PROGRAM IB REGULAR (CIP IB):
A Medicaid-funded waiver program which provides community services to persons with developmental disabilities who are relocated or diverted from nursing homes and Intermediate Care Facilities – Mental Retardation (ICFs-MR) other than the State Centers for the Developmentally Disabled.

Funding: GPR/State = Approximately 40% (state Medicaid funding)
Federal = Approximately 60% (federal Medicaid funding)

COMMUNITY INTEGRATION PROGRAM IB (CIP IB)/LOCAL MATCH:
A Medicaid-funded waiver program which provides community services to persons with developmental disabilities who are relocated or diverted from nursing homes and ICFs-MR other than the State Centers for the Developmentally Disabled.

Funding: GPR/State = Approximately 40% (Community Aids, county match, or COP funds)
Federal = Approximately 60% (federal Medicaid funding)

COMMUNITY SUPPORTED LIVING ARRANGEMENTS (CSLA-WAIVER):
A Medicaid-funded waiver program that serves the same target group as CIP IB. CSLA provides funds that enable individuals to be supported in their own homes. The program began as a demonstration in some counties in 1992 and was expanded statewide January 1, 1996.

Funding: GPR/State = Approximately 40% (Community Aids, county match, or COP funds)
Federal = Approximately 60% (federal Medicaid funding)

BRAIN INJURY WAIVER:
A Medicaid-funded waiver that serves a limited number of people with brain injuries who need significant supports in the community. The person must be receiving or is eligible to receive post-acute rehabilitation services in a nursing home or hospital certified by Wisconsin Medicaid as a special unit for brain injury rehabilitation. This program began January 1, 1995.

Funding: GPR/State = Approximately 40% (state Medicaid funding)
Federal = Approximately 60% (federal Medicaid funding)

Appendix C

QUALITY ASSURANCE AND IMPROVEMENT OUTCOMES

Wisconsin has implemented a plan to demonstrate and document quality assurance efforts, which will ensure the health, safety and welfare of community waiver program participants. The quality assurance and improvement program combines a number of activities to assess and monitor program integrity, customer safety, customer satisfaction and program quality. The information obtained is provided as feedback to local and state agencies to promote quality improvement.

PROGRAM INTEGRITY

On-site monitoring reviews were conducted for a random selection of 550 cases in 2000. The reviews went well beyond the traditional federal requirements, which only identify payment errors, in an effort to gain in-depth information on program operation and policy interpretation. Where errors were identified, corrective action plans were implemented. For all criteria monitored, 89% compliance with the waiver requirements was verified. A summary of the monitoring categories and findings are as follows:

Category: FINANCIAL ELIGIBILITY

Monitoring Components:

Medicaid financial eligibility as approved in state plan
Cost share
Spend down

Findings: *98% of the factors monitored indicated no deficiency. Errors were detected in more complex areas of calculation, such as cost share and spend down. These areas have been emphasized in corrective action plans and technical assistance activities.*

Category: NON-FINANCIAL ELIGIBILITY

Monitoring Components:

Health form
Functional screen

Findings: *91% overall compliance with eligibility was measured. No instances of incorrect eligibility determination were identified under this category, although some cases showed a deficit in documentation that was remedied. Systems of enhanced internal quality control have been implemented in those agencies with documentation issues.*

Category: SERVICE PLAN

Monitoring Components:

Individual Service Plan (ISP) developed and reviewed with participant
Services waiver allowable
Services appropriately billed

Findings: *92% of factors were in compliance. In a small percentage of the cases, timely ISP review, omission of identified services within the ISP, or inclusion of non-allowable costs resulted in negative findings and a disallowance of state/federal funding.*

Category: SERVICE STANDARDS AND REQUIREMENTS

Monitoring Components:

Waiver-billed services met necessary standards and identified needs
Care providers appropriately trained and certified

Findings: *78% of factors were documented as error free. Documentation deficits accounted for many of the negative findings under this category. Corrective action plans were implemented where warranted.*

Category: BILLING

Monitoring Components:

Services accurately billed
Only waiver allowable providers billed
Residence in waiver allowable settings during billing period

Findings: *88% compliance was found in these categories. A process has been implemented to assist in improving billing accuracy. Reports are being generated to assist local agencies in identifying and correcting such errors throughout their caseloads. Corrective action plans were implemented where warranted.*

Category: SUBSTITUTE CARE

Monitoring Components:

Currently licensed
Only waiver allowable costs calculated and billed

Findings: *87% overall compliance was found. Documentation or charging errors due to room and board versus care and supervision were identified in a few cases. A training module has been developed to assist in clarifying this complex area of policy. Corrective action plans were implemented where warranted.*

CORRECTIVE ACTION

A written report of each monitoring review was provided to the director of the local agency responsible for implementing the waiver participant's service plan. The reports cited any errors or deficiencies and required that the deficiency be corrected within a specified period of time, between 1 and 90 days. Follow-up visits were conducted to ensure compliance when written documentation was insufficient to provide assurance. Where a deficiency correlated with ineligibility, agencies were instructed to correct their reimbursement requests. All agencies complied by modifying their practices and acknowledging the deficiencies.

In 2000, a total of 40 agencies were monitored, 31 with full reviews and 9 with reviews of newly implemented internal recertification systems. In 15 instances, disallowances were taken from counties where retroactive corrections could not be implemented. The average disallowance within those 15 counties was $2,791. Disallowances were taken in areas including billing of non-allowable services, data entry errors, lack of documentation for billed services, billing during a period of ineligibility for waiver services, and inaccurate collection of cost share.

PROGRAM QUALITY

During 2000, 550 randomly selected participants responded to 22 questions during in-person interviews regarding satisfaction with waiver services. Both direct responses and reviewer assessments of those responses were recorded.

The factors studied regarding care management services were:

- ❑ Responsiveness to consumer preferences
- ❑ Quality of communication
- ❑ Level of understanding of consumer's situation
- ❑ Professional effectiveness
- ❑ Knowledge of resources
- ❑ Timeliness of response

The factors studied for in-home care were:

- ❑ Timeliness
- ❑ Dependability
- ❑ Responsiveness to consumer preferences

The factors studied for persons living in substitute care settings were:

- ❑ Responsiveness to consumer preferences
- ❑ Choices for daily activities
- ❑ Ability to talk with staff about concerns
- ❑ Comfort

Table 28 combines and summarizes the findings of the survey. Satisfaction in substitute (residential) care settings is somewhat lower than satisfaction with services in one's own home.

Table 28
Program Quality Results

SATISFACTION CATEGORY	PERCENTAGE OF POSITIVE RESPONSES
Care manager is effective in securing services	96%
Good communication with care manager	97%
Care manager is responsive	97%
Active participation in care plan	96%
Satisfaction with in-home workers	96%
Substitute care services are acceptable	96%
Satisfaction with substitute care living arrangement	91%

QUALITY IMPROVEMENT PROJECTS

The information collected from various quality assurance efforts was incorporated into a variety of ongoing quality improvement projects. An overview of those projects is listed below:

- Provide issue specific or county specific intensive monitoring or training where significant errors have been identified. Repeat monitoring where necessary;
- Develop issue specific technical assistance documents. Quarterly, this includes answers to the most frequently asked questions;
- Conduct statewide training in the areas of: Fiscal Management, Advanced Care Manager/Economic Support Training, and Plan Development and Care Management Techniques;
- Utilize enhanced data collection and reporting formats to identify target areas for monitoring and technical assistance, including a reporting system for technical assistance requests and responses;
- Produce and distribute case specific fiscal reports containing potential correctable reporting errors;
- Review certification and recertification procedures to identify more efficient and effective practices; and
- Conduct enhanced interviews to determine customer satisfaction.